

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00554 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
00551											
1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 15 6 mo. 14 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) EASTERN SHORE STATE Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton 2029-2 d. STREET ADDRESS 613 S. Washington St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ROBERT E			First Middle Last Aldrich Sr.			4. DATE OF DEATH JANUARY 21 1962			Month Day Year		
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/11/81		9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days 5 11 IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BANKER				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William T. Aldrich						14. MOTHER'S MAIDEN NAME CARRIE TERRELL					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 183-03-6736		17. INFORMANT RECORDS E.S.S. HOSP. Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) TERMINAL PNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 903.7 DUE TO FRACTURE NECK R. FEMUR (b) DUE TO (c) 3 DAYS 6 WEEKS											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NO											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell on floor							
20c. TIME OF INJURY Month, Day, Year 4:15 p.m. 12-10-1961				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOSPITAL		20f. (City or town) CAMBRIDGE (County) MD (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE John Mace Jr. EXAMINER'S NAME (Type) JOHN MACE JR.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. DATE SIGNED 1/22/62					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Jan 15, 1962						22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY St. Paul Church Hill		22d. LOCATION (City, town, or country) Phila. (State) Pa.	
23. FUNERAL DIRECTOR Edgar L. Lane ADDRESS Church Hill						24a. REC'D BY REGISTRAR DATE JAN 24 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

00555

CERTIFICATE OF DEATH

Reg. Dist. No. 00553

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woolford		c. LENGTH OF STAY IN lb life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woolford			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alexander Bailey				4. DATE OF DEATH Month January Day 20 Year 1962			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 26, 1907		9. AGE (In years last birthday) yrs. 54	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Dor-Co-Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John W. Bailey				14. MOTHER'S MAIDEN NAME Martina Bryan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes WW II		16. SOCIAL SECURITY NO. 217-10-8255		17. INFORMANT Mrs Martina Bailey-Woolford, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 491X IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1wk	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 13, 1962 to January 20, 1962 that I last saw the deceased alive on January 20, 1962 , and that death occurred at 11 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 227 Pine St., Cambridge, Md. DATE SIGNED 1-20-62							
ACTUAL SIGNATURE <i>[Signature]</i>		M.D. J. Edwin Fassett, M.D.					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 1/24/62		22c. NAME OF CEMETERY OR CREMATORY Madison Cemetery		22d. LOCATION (City, town, or county) (State) Madison-Dor-Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i> ADDRESS High St., Cambridge, Md.				24a. REC'D BY REGISTRAR JAN 30 '62		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00556									
00554									
1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) rural Cambridge, Md c. LENGTH OF STAY IN 1b 4 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eastern Shore State Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 13 Cambridge d. STREET ADDRESS 1 401 Henry St. n. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print!) First John Middle Victor Last Bell					4. DATE OF DEATH Month January Day 28 Year 19 62				
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/ 20/ 77		9. AGE (In years last birthday) 84 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) waterman				10b. KIND OF BUSINESS OR INDUSTRY Fishing		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Bell					14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Medical Records, ESSH Cambridge, Md. Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: arteriosclerotic heart disease, decompensated IMMEDIATE CAUSE (a) 4+20.0 DUE TO (b) unk Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1/25/ 19 62 to 1/28 3:15 P.M. , that (I) (we) last saw the deceased alive on 1/28/ 19 62 , and that death occurred at 1/28 3:15 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Houston Foster M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 1/28/62		
22c. PHYSICIAN'S NAME (Type) Houston Foster, MD					22d. ADDRESS E.S.S.H. Cambridge, Md				
23a. BURIAL, CREMATION, REMOVAL (Specify) B		23b. DATE THEREOF Jan. 31, 1962		23c. NAME OF CEMETERY OR CREMATORY CAMB		23d. LOCATION (City, town or county) (State) Castle Haven, Maryland.			
24. FUNERAL DIRECTOR'S SIGNATURE LECOMPTRE FUNERAL SER. MD ADDRESS					25a. REC'D BY REGISTRAR FEB 1 '62 DATE		25b. REGISTRAR'S SIGNATURE Arthur E. Kinnear		

50554

50554
50554
50554

50554
50554
50554

50554
50554
50554

50554
50554
50554

50554
50554
50554

50554
50554
50554

50554
50554
50554

50554
50554
50554

50554
50554
50554

50554
50554
50554

50554
50554
50554

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

Maryland STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00557 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00555

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN b 24 yr. 3 mo. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eastern Shore State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Centreville d. STREET ADDRESS - e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Edith Catherine Brown		4. DATE OF DEATH Month Day Year January 9 19 62	
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-8-79
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Madison Brown		14. MOTHER'S MAIDEN NAME Priscilla Emory	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. -	
17. INFORMANT RECORDS - Eastern Shore State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture neck humerus. Diabetes Mellitus 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Slipped and fell to floor 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour, e.m. 12.35 PM 1/10/62 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital ward 20f. (City or town) (County) (State) Cambridge Dor. Md. 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 1/9/62 ACTUAL SIGNATURE John Mace Jr. EXAMINER'S NAME (Type) 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 1/14/62 22c. NAME OF CEMETERY OR CREMATORY Chester Field 22d. LOCATION (City, town, or country) (State) Centreville Md 23. FUNERAL DIRECTOR Edgar L Lane Church Hill Md ADDRESS 24a. REC'D BY REGISTRAR JAN 15 '62 24b. REGISTRAR'S SIGNATURE Arthur L. Krum			

0257

(M)

Examination of the

Examination of the

Examination of the

11.11.11

11.11.11

11.11.11

11.11.11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1

(M)

67

1

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00558											
00556											
1. PLACE OF DEATH a. COUNTY Dorchester Co. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md. c. LENGTH OF STAY IN 1b 50 Years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Md. Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Dorchester Co. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge, Md. d. STREET ADDRESS 108 Cemetery Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Lucy Foxwell First Middle Last Cannon						4. DATE OF DEATH Month Day Year Jan. 6 1962					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 28, 1872		9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None				11. BIRTHPLACE (County & State, or foreign country) Meekins Neck, Dorchester, Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert M. Foxwell						14. MOTHER'S MAIDEN NAME Margaret Ann Foxwell					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Phillip Cannon		Address 108 Cemetery Ave. Camb.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 525X DUE TO Conditions, if any, which gave rise to immediate cause (b) Fibrosis Lungs (severe) (a), stating the underlying cause last. DUE TO Seizure (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Collapse Dorsal Vertebrae INTERVAL BETWEEN ONSET AND DEATH 5 days											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) Jan. 2, 1962 Jan. 7, 1962											
21. I certify that (I) (this hospital) attended the deceased from Jan. 2, 1962 to Jan. 7, 1962 that (I) (we) last saw the deceased alive on Jan. 7, 1962 and that death occurred at M , from the causes and on the date stated above.											
22a. SIGNATURE [Signature] M.D. 22c. PHYSICIAN'S NAME (Type) Dr. W. H. Hanks						22b. DATE SIGNED ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Cambridge, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 8, 1962		23c. NAME OF CEMETERY OR CREMATORY Cambridge Cemetery				23d. LOCATION (City, town or county) (State) Cambridge, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service						ADDRESS Cambridge Md.		25a. REC'D BY REGISTRAR JAN 12 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Hanks	



100,000 100,000 100,000 100,000 100,000 100,000 100,000 100,000 100,000 100,000

100,000 100,000 100,000 100,000 100,000 100,000 100,000 100,000 100,000 100,000

100,000 100,000 100,000 100,000 100,000 100,000 100,000 100,000 100,000 100,000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00559

00557

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md.</u>	
c. LENGTH OF STAY in 1b <u>2 Years</u>		d. STREET ADDRESS <u>Locust St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Glasgow Nurseing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Benjamin</u> Middle <u>Cyrus</u> Last <u>Carmine</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>17,</u> Year <u>19 62</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 26, 1887</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>13</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		12. IF UNDER 24 HRS. Hours <u>17</u> Min. <u>19</u>	
13. FATHER'S NAME <u>Benjamin Carmine</u>		14. BIRTHPLACE (County & State, or foreign country) <u>Lewis, Del.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mrs. James Thompson</u>		18. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure, congestive</u> DUE TO (b) <u>arterio-sclerotic CVD & coronary insufficiency - 10 yrs</u> DUE TO (c) <u>arterio-sclerotic Jan</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dr. cerebral thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>1 yr.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1951</u> to <u>Jan 17, 1962</u> that (I) (we) last saw the deceased alive on <u>Jan 17, 1962</u> and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>James H. Thompson</u>		22b. DATE SIGNED <u>1/19/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. V. Thompson</u>		22d. ADDRESS <u>Cambridge, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 19, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Christ Churchyard</u>		23d. LOCATION (City, town or county) (State) <u>Cambridge, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>		25a. REC'D BY REGISTRAR <u>JAN 29 1962</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>		25c. DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00558

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 4 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glasgow Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) First Alice Middle Donovan Last Cook		4. DATE OF DEATH Month January Day 22 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 2, 1887
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR: Months 7 Days 4 Hours 15 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		11b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Hoboken, N.J.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Augustine Donovan		14. MOTHER'S MAIDEN NAME Anna Laura Harrison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Maj. Henry R. Cook, Claiborne, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Broncho-pneumonia DUE TO Arterio-cardio-vascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 24 hours 1 year +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 a. p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-30-61 , 19 61 , to 1-22-62 , 19 62 , that I last saw the deceased alive on 1-22-62 , 19 62 , and that death occurred at 7:30 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 15 Locust Street DATE SIGNED 1-22-62			
ACTUAL SIGNATURE Eldridge H. Wolff		M.D. 15 Locust Street	
PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M.D.		Cambridge, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 25, 1962	
22c. NAME OF CEMETERY OR CREMATORY St. Dennis Cemetery		22d. LOCATION (City, town, or county) (State) Havertown, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Benjamin R. Shuman		ADDRESS Cambridge, Md.	
24a. REC'D BY REGISTRAR JAN 29 '62		24b. REGISTRAR'S SIGNATURE Arthur J. ...	

00561

CERTIFICATE OF DEATH

Reg. Dist. No.

00559

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	c. LENGTH OF STAY IN 1b five yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md Hospital		d. STREET ADDRESS 156 Washington St	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Jannie Middle E. Last Cooper		4. DATE OF DEATH Month January Day 12 Year 1962	
5. SEX female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 13, 1895
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min. 66	IF UNDER 24 HRS Months 66 Days 66 Hours 66 Min. 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Canning Factory	11. BIRTHPLACE (State or foreign country) Dor-Co-Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Keene	
14. MOTHER'S MAIDEN NAME Mary R. Lee		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]	
16. SOCIAL SECURITY NO. 220-01-7961		17. INFORMANT Miss Virginia Cooper-Cambridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Hemorrhage 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Renal Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 wks
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Cambridge		(County) (State)	
21. I certify that I attended the deceased from January 2, 1962 to January 12, 1962 that I last saw the deceased alive on January 12, 1962 and that death occurred at Cambridge, Md. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 227 Pine St., Cambridge, Md. DATE SIGNED 1-13-62			
ACTUAL SIGNATURE <i>J. Edwin Fassett</i>		M.D. J. Edwin Fassett, M.D.	
PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 1/14/62		22c. NAME OF CEMETERY OR CREMATORY Madison Cemetery	
22d. LOCATION (City, town, or county) Madison-Dor-Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Richard H. Soper</i>		ADDRESS High St-Cambridge, Md.	
24a. REC'D BY REGISTRAR DATE JAN 30 62		24b. REGISTRAR'S SIGNATURE <i>Richard H. Soper</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be completed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Eastern Shore State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> d. STREET ADDRESS <u>Locust St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ETHEL</u> Middle <u>HENRY</u> Last <u>FELL</u>		4. DATE OF DEATH Month <u>January</u> Day <u>19</u> Year <u>1962</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/25/1877</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>24</u>	
11. IF UNDER 24 HRS Hours <u>1</u> Min. <u>24</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Hampton HENRY</u>		14. MOTHER'S NAME <u>Le Compte</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>MISS Helen W. Fell, Aurora St., Cambridge</u>	
17. INFORMANT <u>Miss Helen W. Fell, Aurora St., Cambridge</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiovascular degeneration</u> +22.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>years</u> DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>Md.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 29, 1955</u> to <u>Jan 19, 1962</u> that (I) (we) last saw the deceased alive on <u>Jan 29, 1962</u> and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>John F. Schneider</u> M.D.		22b. DATE <u>Jan 19 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>John F. Schneider</u>		22d. ADDRESS <u>Eastern Shore State Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 22, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Christ Church Cemetery Cambridge, Md.</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas Fenwick Home</u>		25a. REC'D BY REGISTRAR <u>Jan 24 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>William S. Hall</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be re-executed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY DORCHESTER		b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) CAMBRIDGE, MD.		c. LENGTH OF STAY IN 1b SINCE 1-22-51		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND		b. COUNTY QUEEN ANNE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CENTREVILLE R.F.D. 3 BOX 31		d. STREET ADDRESS RFD# 3 Centreville, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) CARTER EDMONDS GRAVES SR.		4. DATE OF DEATH Month JANUARY Day 27 Year 1962		5. SEX M		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-3-85		9. AGE (In years last birthday) 76 7/17 yrs		10. IF UNDER 1 YEAR Months 7 Days 17 Hours 17 Min. 17					
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Seldon Graves		14. MOTHER'S MAIDEN NAME Lena Edmonds		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Unknown		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO 42 Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ATHEROSCLEROTIC C.V.D. DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH 1 HOUR 2 YEARS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ASCENDING URINARY TRACT INFECTION; PNEUMONITIS												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) CENTREVILLE		20g. (County) QUEEN ANNE		20h. (State) MARYLAND					
21. I certify that (I) (this hospital) attended the deceased from 1-13 1962 to 1-27 1962, that (I) last saw the deceased alive on 1-26 1962 and that death occurred at 12:45 , from the causes and on the date stated above.												22a. SIGNATURE GEO. M. DUNN M.D.				22b. DATE SIGNED 22			
22c. PHYSICIAN'S NAME (Type) GEO. M. DUNN, M.D.		22d. ADDRESS EASTERN SHORE STATE HOSPITAL CAMBRIDGE, MARYLAND		23a. BURIAL, CREMATION, REMOVAL (Specify) 13		23b. DATE THEREOF 1/29/62		23c. NAME OF CEMETERY OR CREMATORY GARTH CHAPEL		23d. LOCATION (City, town, or county) ALBEMARLE		23e. (State) VA		23f. REGISTRAR'S SIGNATURE Carlton E. Hagan					
24. FUNERAL DIRECTOR'S SIGNATURE HAYNES FUNERAL SR		ADDRESS CAMB. MD.		25a. REC'D BY REGISTRAR FEB 1 1962		25b. REGISTRAR'S SIGNATURE Carlton E. Hagan		25c. DATE FEB 1 1962		25d. REGISTRAR'S SIGNATURE Carlton E. Hagan		25e. DATE FEB 1 1962		25f. REGISTRAR'S SIGNATURE Carlton E. Hagan					

00563

00561

Item 9 Film 0306 0306 2/5/62 iwk

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00564

00562

1. PLACE OF DEATH a. COUNTY <u>Lancaster</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> c. LENGTH OF STAY IN <u>From 9/30/58</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Eastern Shore State Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Clayborn</u> d. STREET ADDRESS <u>CLAYBORN, MARYLAND</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Clarence</u>		First <u>Moore</u> Middle <u>Hadaway</u> Last <u>Hadaway</u>		4. DATE OF DEATH Month <u>January</u> Day <u>21</u> Year <u>1962</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>10/12/1881</u>		9. AGE (In years last birthday) <u>80</u> yrs. <div style="display: flex; justify-content: space-between; font-size: small;"> IF UNDER 1 YEAR IF UNDER 24 HRS </div> Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>			
10b. KIND OF BUSINESS OR INDUSTRY <u>NO.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>JOHN Hadaway</u>			14. MOTHER'S MAIDEN NAME <u>Sarah Campbell</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>015-14-4094</u>				
17. INFORMANT <u>Eastern Shore State Hospital</u>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 450.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Generalized arteriosclerosis</u> (c) <u> </u>				
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Cere. Brain Syndrome associated with Senile Brain Disease, Psych.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) <u> </u>		20g. (County) <u> </u>		20h. (State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>9/30/1958</u> , 19 , to <u>1/21</u> , 1962 , that (I) (we) last saw the deceased alive on <u>Jan. 20</u> , 1962 , and that death occurred at <u>12:00</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Simon Virkutis</u>			22b. DATE SIGNED <u>1/21/1962</u>				
22c. PHYSICIAN'S NAME (Type) <u>Simon VIRKUTIS</u>			22d. ADDRESS <u>E. S. S. Hospital, January 21, 1962</u>				
23a. BURIAL CREMATION <u>Removal (Specify)</u>		23b. DATE THEREOF <u>1-24-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Heavly Cemetery</u>			
23d. LOCATION (City, town or county) <u>Heavly, Md</u>		23e. (State) <u> </u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Franklin Harrison</u>			25a. REC'D BY REGISTRAR <u>St. Michael's</u>				
25b. REGISTRAR'S SIGNATURE <u> </u>			25c. DATE <u>JAN 23 '62</u>				

MEDICAL CERTIFICATION

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. It may be signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00565

00564

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN lb 1 yr. 3 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillsboro		65X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First ETHEL		Middle S		Last HOLT	
4. DATE OF DEATH		Month Jan		Day 17		Year 1962	
5. SEX F	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-24-83		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Holt, James				14. MOTHER'S MAIDEN NAME Beaver, Grace			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 213-12-5483		17. INFORMANT Hospital records Cambridge Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 241X BRONCHIAL ASTHMA DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH unk							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hillsboro		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 17 1960, to Jan 17 1962 that (I) (we) last saw the deceased alive on Jan 16 1962, and that death occurred at 1238 M, from the causes and on the date stated above.							
22a. SIGNATURE Thomas J. Dredge				M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 1-17-62	
22c. PHYSICIAN'S NAME (Type) Thomas J. Dredge, M.D.				22d. ADDRESS E.S.S. Hospital, Cambridge, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF Jan 29/62	23c. NAME OF CEMETERY OR CREMATORY Hillsboro Md		23d. LOCATION (City, town, or county) Hillsboro		(State) Md	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Moon & Son Denton				25a. REC'D BY REGISTRAR DATE JAN 23 '62		25b. REGISTRAR'S SIGNATURE C. S. R. R. R.	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00566
00565
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> c. LENGTH OF STAY (in days) <u>3 wks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cambridge Maryland</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Dor</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harlock - Rural</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles Augustus Howard</u> First Middle Last 4. DATE OF DEATH <u>1 / 11 / 1962</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>Caucasian</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>7/13/1883</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (in years and birthday) <u>78</u> yrs. 10. IF UNDER 1 YEAR: Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Raydoner</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State or foreign country) <u>North Carolina</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Don't know</u> 14. MOTHER'S MAIDEN NAME <u>Don't know</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service) 16. SOCIAL SECURITY NO. <u>170-20-7095</u> 17. INFORMANT <u>Mrs Elizabeth Howard</u> Address <u>Harlock, Md</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Arteriosclerotic Heart Disease</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>December 21, 1961</u> to <u>Jan 11, 1962</u> , that (I) (we) last saw the deceased alive on <u>January 11, 1962</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>J. Edwin Fassett</u> 22c. PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, Md.</u>		22b. DATE SIGNED <u>1/13/62</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>227 Pine St., Cambridge, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>1/14/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u> 23d. LOCATION (City, town or county) (State) <u>East New Market Md</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Hines</u> 25b. REGISTRAR'S SIGNATURE DATE <u>JAN 26 '62</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00567

00566

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Secretary</u> c. LENGTH OF STAY IN <u>10 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospite, give street address) _____				2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Dor</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Secretary</u> d. STREET ADDRESS _____			
3. NAME OF DECEASED (Type or print) <u>Edith Constable</u> First Middle Last 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>2/11/1886</u> 9. AGE (In years last birthday) <u>75</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Penna U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Harry S Constable</u> 14. MOTHER'S MAIDEN NAME <u>Margaretta Harding</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ 16. SOCIAL SECURITY NO. _____ 17. INFORMANT <u>Mrs. Gerald Wilkins, Secretary Md.</u> Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>156.1</u> DUE TO <u>Cachexia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Carcinomatosis</u> (b) <u>Hepatic</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) _____ 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____				21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 7</u> , 19 <u>59</u> to <u>Jan. 5</u> , 19 <u>62</u> ; that (I) (we) last saw the deceased alive on <u>Jan. 5</u> , 19 <u>62</u> , and that death occurred at <u>7 A</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Jason F. B. Yeend</u> 22b. DATE SIGNED <u>1-8-62</u> 22c. PHYSICIAN'S NAME (Type) <u>JASON F. B. YEEND, M.D., Hurlloch Md</u> 22d. ADDRESS _____				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> 23b. DATE THEREOF <u>1/8/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Washington</u> 23d. LOCATION (City, town or county) <u>Hurlloch Md</u> (State) _____			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Carl S. Thoroughly</u> ADDRESS <u>East New Market</u> 25a. REC'D BY REGISTRAR <u>JAN 11 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>				26. _____			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00568

Item 7 Film 6-05 17-6/6-1wr

00568

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural, East New Market</u>		c. LENGTH OF STAY IN b. <u>17-6/6-1wr</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Dorchester</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural East New Market</u>		d. STREET ADDRESS <u>R.F.D. Cabin Creek Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Amos Hubert Jackson</u>		4. DATE OF DEATH <u>January 10 1962</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 11, 1892</u>		9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u>		11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Day Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles W. Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Annie Thompson</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u>217-03-8014</u>		17. INFORMANT <u>Alma Conaway</u> Address <u>East New Market, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>4-20-1</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> DUE TO <u> </u> cause last. (c) <u> </u>																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year <u> </u> <u> </u> <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>																	
22b. DATE THEREOF <u>1/13/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>East New Market Cemetery</u>		22d. LOCATION (City, town, or country) <u>Dorchester, Md.</u>		22e. PLACE OF INJURY (Street, city, town, or country) <u>Cambridge, Md.</u>		22f. LOCATION (City, town, or country) <u> </u>		22g. LOCATION (City, town, or country) <u> </u>		22h. LOCATION (City, town, or country) <u> </u>		22i. LOCATION (City, town, or country) <u> </u>			
23. FUNERAL DIRECTOR <u>Ruth Willoughby</u>		ADDRESS <u>East New Market, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 18 '62</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Evans</u>		24c. REGISTRAR'S SIGNATURE <u> </u>		24d. REGISTRAR'S SIGNATURE <u> </u>		24e. REGISTRAR'S SIGNATURE <u> </u>		24f. REGISTRAR'S SIGNATURE <u> </u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00568

00568

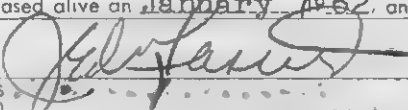

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge-Rural d. STREET ADDRESS RFD #3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mannie First Jenkins Middle Lost		4. DATE OF DEATH January 18, 1962 Month 18 Day 19 Year 62	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 22, 1879 9. AGE (In years last birthday) yrs. 82 IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Dor-Co-Md.	11. BIRTHPLACE (State or foreign country) USA
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John W. Jenkins	
14. MOTHER'S MAIDEN NAME Eliza Tubman		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO 214-07-7713		17. INFORMANT Mrs. Carrie Jenkins-Cambridge, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 4, 1962 , to January 18, 1962 , that I last saw the deceased alive on January 18, 1962 , and that death occurred at 8 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 227 Pine St., Cambridge, Md-1-19-62			
ACTUAL SIGNATURE J. Edwin Fassett, M.D.		M.D. 227 Pine St., Cambridge, Md-1-19-62	
PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/21/62	
22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE High St., Cambridge, Md.		24a. REC'D BY REGISTRAR DATE JAN 30 '62	
24b. REGISTRAR'S SIGNATURE W. S. Thomas			

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00570

00569

1 PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				c. LENGTH OF STAY IN Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital				e. STREET ADDRESS Railroad Hill			
3 NAME OF DECEASED (Type or print) First Corinthian Middle Martin Last Jolley				4. DATE OF DEATH Month January Day 7 Year 19 62			
5 SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 26, 1961	
9 AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months 11 Days 11		IF UNDER 24 HRS Hours 11 Min 11		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Cambridge, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas Henry Jolley	
14. MOTHER'S MAIDEN NAME Essie Batson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Essie B. Jolley, East New Market, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Premature DUE TO 7-10 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 13 days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State) December 26, 61 to January 7 19 62			
21. I certify that (I) (this hospital) attended the deceased from December 26, 61 to January 7 19 62 that (I) (we) last saw the deceased alive on January 7 19 62 and that death occurred 12:45 AM from the causes and on the date stated above							
22a. SIGNATURE 				22b. DATE SIGNED 12:45 AM			
22c. PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.				22d. ADDRESS 227 Pine St., Cambridge, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 8, 1962		23c. NAME OF CEMETERY OR CREMATORY East New Market Cemetery		23d. LOCATION (City, town, or county) (State) East New Market, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE J.J. Framptom and Son, Federalsburg, Maryland				25a. REC'D BY REGISTRAR DATE JAN 11 '62		25b. REGISTRAR'S SIGNATURE 	

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The funeral director, by the hospital, or attending physician, may be retained by the hospital for the purpose of signing this certificate. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00570

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Hurlock - Rural		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock - Rural		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Near Williamsburg				d. STREET ADDRESS 1 Near Williamsburg			
3. NAME OF DECEASED (Type or print) First Rita Middle Charmaine Last Jolley				4. DATE OF DEATH Month January Day 1 Year 19 62			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 11, 1961		9. AGE (In years last birthday) yrs 20	IF UNDER 1 YEAR Months 20	IF UNDER 24 HRS Hours 20 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Easton, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Mac Sims				14. MOTHER'S MAIDEN NAME Evelyn Jolley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None		17. INFORMANT Evelyn Jolley, Hurlock, Md., RFD #1, Box 132A			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 47.5 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Upper respiratory infection DUE TO (c) Smoke inhalation INTERVAL BETWEEN ONSET AND DEATH 8 hrs. 5 days 10 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Smoke inhalation followed accidental fire within house-child then exposed to winter weather						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) Natural causes		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Smoke inhalation followed accidental fire within house-child then exposed to winter weather		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street office bldg., etc.) home		20f. (City or town) Dorchester		(County) Md.		(State)	
21. I certify that (I) (this hospital) attended the deceased from 12.11.1961 to 1.1.1962 , that (I) (we) last saw the deceased alive on 12.26.61 , and that death occurred at 6:50 PM M, from the causes and on the date stated above.							
22a. SIGNATURE H. R. Trapnell, M.D.				22b. DATE 1.4.62		22c. ADDRESS Federalburg, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 4, 1962		23c. NAME OF CEMETERY OR CREMATORY Federal Hill Cemetery		23d. LOCATION (City, town, or county) (State) Federalburg, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalburg, Maryland				25a. REC'D BY REGISTRAR DATE JAN 8 '62		25b. REGISTRAR'S SIGNATURE C. J. S. Frame	

2080214204

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18, Form 306 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00572 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00572									
1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Dorchester				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna					c. LENGTH OF STAY IN 1b All life				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Middle Street					d. STREET ADDRESS Middle Street				
3. NAME OF DECEASED (Type or print) Earl Ralph Jones					4. DATE OF DEATH January 24 1962				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH March 31, 1905		9. AGE (In years last birthday) 56 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME William Jones					14. MOTHER'S MAIDEN NAME Lillian Todd				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No					16. SOCIAL SECURITY NO. 217-05-8044				
17. INFORMANT J. Sard Jones					18b. ADDRESS 186 Kenton Ave., Newark, Del.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>PENDING</u> DUE TO Acute alcoholism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Undet</u> (c) <u>Undet</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Undet</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural forces <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Alfred R. M. Ryanov, M. D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 136 Race St., Cambridge Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 1/26/62		22c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial		22d. LOCATION (City, town, or county) (State) Cambridge Md.		
23. FUNERAL DIRECTOR Luth S. Tillinghly, East New Market, Md.					24. REC'D BY REGISTRAR JAN 30 '62		24b. REGISTRAR'S SIGNATURE Luth S. Tillinghly		

00573 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00572

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge				c. LENGTH OF STAY IN 1b 7 mo. 1 day			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eastern Shore State Hospital				d. STREET ADDRESS -			
3. NAME OF DECEASED (Type or print) First Florence Middle - Last Jones				4. DATE OF DEATH Month January Day 31 Year 1962			
5. SEX Female		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-20-1881	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months - Days -		IF UNDER 24 HRS. Hours - Min. -			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Clarence S. Hurlock				14. MOTHER'S MAIDEN NAME Addie McGinnis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None				16. SOCIAL SECURITY NO. None			
17. INFORMANT RECORDS - Eastern Shore State Hospital				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus DUE TO 4 - 2 - 1 Conditions, if any, which gave rise to immediate cause (b) Congestive Heart Failure (a), stating the underlying cause last 3 days (c) Complicated by aspiration of stomach contents PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 3 days							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Hour a.m. 19 Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 1/31/62							
ACTUAL SIGNATURE Alfred R. Maryanov		EXAMINER'S NAME (Type) ALFRED R. MARYANOV		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 5, 1962		22c. NAME OF CEMETERY OR CREMATORY Cecilton Cemetery		22d. LOCATION (City, town, or country) (State) Cecilton, Cecil Co; Md.	
23. FUNERAL DIRECTOR Edward S. Williams				24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE February 2 '62 Arthur S. Evans			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00574

00573

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admision) a. STATE <u>Del. Md.</u>		b. COUNTY <u>Sussex Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md.</u>		c. LENGTH OF STAY IN 1b <u>3 Year</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seaford</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp'te, give street address) <u>Glasgow Nursing Home</u>		d. STREET ADDRESS <u>206 Spruce St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Harry S. Kennan</u>		4. DATE OF DEATH <u>Jan. 5, 1962</u>		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
8. DATE OF BIRTH <u>July 19, 1873</u>		9. AGE (In years last birthday) <u>88 yrs.</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RR Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penna. RR</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Chillicothe, Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Thomas E. Keenan</u>		14. MOTHER'S MAIDEN NAME <u>Mary O. Snyder</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Spanish American Unknown</u>		17. INFORMANT <u>Harry E. A. Keenan</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>334 X</u> DUE TO <u>Medullary paralysis</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <u>Cerebral Arterio-sclerosis</u> DUE TO <u>Arterio-sclerosis gen.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>None</u>		19. INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>young</u> <u>young</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. (City or town) <u>Cambridge, Md.</u>	
21. I certify that (I) (this hospital) attended the deceased from 1958 to Jan. 5, 1962, that (I) (we) last saw the deceased alive on Jan. 4, 1962, and that death occurred at M, from the causes and on the date stated above.		22a. SIGNATURE <u>J. W. Thompson</u>		22b. DATE SIGNED <u>Jan. 5, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. W. Thompson</u>		22d. ADDRESS <u>Cambridge, Md.</u>		22e. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 7, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cambridge Cemetery</u>	
23d. LOCATION (City, town or county) <u>Cambridge, Md.</u>		23e. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		23f. DATE <u>JAN 10 '62</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>		24b. ADDRESS <u>Cambridge, Md.</u>		24c. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



FOR STATE
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00575

00574

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
c. LENGTH OF STAY IN IS 1 day		d. STREET ADDRESS 115 Gay street	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge-Maryland Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rosalie Bassett Meekins		4. DATE OF DEATH January 19, 1962	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 9, 1903	
9. AGE (In years last birthday) 58 yrs.		10. BIRTHPLACE (State or foreign country) Salem, Md.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John W. Bassett		14. MOTHER'S MAIDEN NAME Emma May McKnett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) No		16. SOCIAL SECURITY NO. 214007-7247	
17. INFORMANT Mrs. R. Graham Fries		Address Cambridge, Md. R.D. 1	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH 5 Min.	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Aspiration stomach contents. CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last Second & Third degree burns arms and legs. DUE TO Second & Third degree burns arms and legs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bed caught fire.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 1 PM 1/18/62		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Cambridge (County) Dor. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Mace Jr.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 21, 1962	
22c. NAME OF CEMETERY OR CREMATORY East New Market Cemetery		22d. LOCATION (City, town, or country) East New Market, Md.	
23. FUNERAL DIRECTOR Kenneth R. Thowson		24a. REC'D BY REGISTRAR DATE JAN 24 '62	
ADDRESS Cambridge, Md.		24b. REGISTRAR'S SIGNATURE Wm. S. Kline	

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00575

00576

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Rural				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital				d. STREET ADDRESS Market St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lillian Middle (Hackett) Last Merrick				4. DATE OF DEATH Month January Day 31 Year 19 62			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 7, 1878	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 83 Days 83 Hours 83 Min. 83		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress				10b. KIND OF BUSINESS OR INDUSTRY Robt. L. Hackett		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Thomas S. Hackett				14. MOTHER'S MAIDEN NAME Charles Anna Shehe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 217-09-3270		17. INFORMANT Address Records-Eastern Shore State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident, left, massive 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic C.V.D. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension							INTERVAL BETWEEN ONSET AND DEATH 15 min. ? years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)							
21. I certify that (a) (this hospital) attended the deceased from December 23 19 61 to January 31 19 62 that (b) (we) last saw the deceased alive on January 31 19 62 , and that death occurred at 10:25 A.M. from the causes and on the date stated above							
22a. SIGNATURE Geo M. Dunn				22b. DATE SIGNED 1/31/62		22c. PHYSICIAN'S NAME (Type) George M. Dunn	
22d. ADDRESS Eastern Shore State Hospital, Cambridge, Md.				22e. REC'D BY REGISTRAR Eastern Shore State Hospital, Cambridge, Md.			
23a. BURNAL, CREMATION, REMOVAL, (Specify)				23b. DATE THEREOF 2/3/62			
23c. NAME OF CEMETERY OR CREMATORY East New Market				23d. LOCATION (City, town, or county) (State) East New Market, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE East New Market				25a. REC'D BY REGISTRAR East New Market		25b. REGISTRAR'S SIGNATURE William S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
00577											
1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>				c. LENGTH OF STAY IN 1b <u>3 Months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Cambridge Md.</u>				d. STREET ADDRESS <u>RFD# 2 Cambridge Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Glenburn Nursing Home</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Lena</u> Middle <u>H.</u> Last <u>Mills</u>						4. DATE OF DEATH Month <u>Jan.</u> Day <u>29</u> Year <u>1962</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APR. 15, 1878</u>		9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Dorchester Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>						14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>						16. SOCIAL SECURITY NO. <u>None</u>					
17. INFORMANT <u>Lake Mills</u>						Address <u>RFD# 2 Cambridge, Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X</u> <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Hour <u> </u> e.m. <u> </u> p.m. <u> </u> Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>4/10</u> , 19 <u>52</u> to <u>2/29/62</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>1/29</u> , 19 <u>62</u> , and that death occurred at <u>A.M.</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>W. H. HANKS</u>						22b. DATE SIGNED <u>2/3/62</u>					
22c. PHYSICIAN'S NAME (Type) <u>W. H. HANKS</u>						22d. ADDRESS <u>104 Locust St Cambridge Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Feb. 1, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Cambridge, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>						ADDRESS <u>Cambridge, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 6 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Wm L. Hanks</u>	

M

I

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. File pages 1, 2, and 3 to the funeral director's files. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00579 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY **Dorchester** MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Chestertown**
c. LENGTH OF STAY IN b **1 yrs. 9 mos. 29 days**
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Eastern Shore State Hospital**

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE **Maryland** b. COUNTY **Kent**
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Chestertown**
d. STREET ADDRESS **?**

3. NAME OF DECEASED (Type or print)
First **Leonard** Middle **Earl** Last **Plummer**
4. DATE OF DEATH **January 28, 1962**

5. SEX **male** 6. COLOR OR RACE **white** 7. ☒ MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED
8. DATE OF BIRTH **3/11/81** 9. AGE (In years last birthday) **80** yrs. IF UNDER 1 YEAR: Months **8** Days **1** IF UNDER 24 HRS.: Hours **1** Min. **55**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **retired farmer** 10b. KIND OF BUSINESS OR INDUSTRY **retired farmer** 11. BIRTHPLACE (State or foreign country) **Maryland** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **William Plummer** 14. MOTHER'S MAIDEN NAME **Catherine L. Siltan**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **no** 16. SOCIAL SECURITY NO. **220-09-8478** 17. INFORMANT **Medical Records ESSH Cambridge, Md**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Myocardial infarction**
Conditions, if any, which gave rise to immediate cause (b) **420-1**
(a), stating the underlying cause last. (c) **Chronic brain syndrome due to circulatory disturbance.**
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) **Chronic brain syndrome due to circulatory disturbance.**

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year **19** Hour a.m. **19** p.m. **19** 20d. INJURY OCCURRED ☒ While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **?** 20f. (City or town) **Baltimore** (County) **?** (State) **Md**

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **John Mace Jr.** EXAMINER'S NAME (Type) **John Mace Jr.** CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED **1/28/62**

22a. BURIAL, CREMATION, or REMOVAL (Specify) **Burial** 22b. DATE THEREOF **1/31/62** 22c. NAME OF CEMETERY OR CREMATORY **Western** 22d. LOCATION (City, town, or country) **Baltimore** (State) **Md**

23. FUNERAL DIRECTOR **Edmund Mace, Catonsville Md** ADDRESS **Catonsville Md** 24a. REC'D BY REGISTRAR **1** 24b. REGISTRAR'S SIGNATURE **Chas. S. Harris**

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00580

00578

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md.</u> c. LENGTH OF STAY IN TB <u>1 Day</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Md. Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bishop Head, Md.</u> d. STREET ADDRESS <u>Bishop Head, Md.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Iris</u> Middle <u>Bramble</u> Last <u>Pritchett</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>27</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 30, 1905</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Bishop Head, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John C. Bramble</u>		14. MOTHER'S MAIDEN NAME <u>Roxy Bramble</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Clarence Pritchett</u>		Address <u>Bishop Head, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Obesity</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/26</u> to <u>1/27</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>1/27</u> , 19 <u>62</u> and that death occurred <u>6:50 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>W. H. Hanks</u>		22b. DATE SIGNED <u>1/29/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. H. HANKS.</u>		22d. ADDRESS <u>CAMBRIDGE MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 30, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park</u>		23d. LOCATION (City, town or county) (State) <u>Cambridge, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>		25a. REC'D BY REGISTRAR <u>Arthur L. Hume</u>	
ADDRESS <u>Cambridge, Maryland</u>		25b. REGISTRAR'S SIGNATURE	
DATE <u>FEB 6 '62</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be completed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 should be filed with the funeral director and completely detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00581
00579
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u> c. LENGTH OF STAY IN 1b <u>2 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cambridge Md. Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Crocheron, Md.</u> d. STREET ADDRESS <u>Crocheron, Md.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Martha Mabel Pritchett</u> First Middle Last 4. DATE OF DEATH <u>Jan. 7, 1962</u> 19 <u>62</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 26, 1897</u> 9. AGE (In years last birthday) <u>64</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Crocheron, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James Riley</u> 14. MOTHER'S MAIDEN NAME <u>Sarah Mills</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Riley W. Pritchett</u> Address <u>Lakesville, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u>Prothetis Mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Supreme Rt lower extremity</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 30, 1961</u> to <u>Jan. 7, 1962</u> , that (I) (we) last saw the deceased alive on <u>Jan. 7, 62</u> , and that death occurred at <u>11:00 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u> M.D. 22b. DATE SIGNED <u>Jan. 7, 1962</u> 22c. PHYSICIAN'S NAME (Type) <u>Dr. W. H. Hanks</u> 22d. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Jan. 9, 1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Bethany Churchyard</u> 23d. LOCATION (City, town or county) (State) <u>Crocheron, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u> ADDRESS <u>Cambridge, Md.</u> 25a. REC'D BY REGISTRAR <u>JAN 12 '62</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

CERTIFICATE OF DEATH

Reg. Dist. No. 00580

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b 5 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock, Maryland d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Girl Middle Smith Last Smith		4. DATE OF DEATH Month January Day 23 Year 1962	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 23, 1962
9. AGE (In years last birthday) 0 yrs.		IF UNDER 1 YEAR Months 5 Days 5 Hours 5 Min. 5	IF UNDER 24 HRS Months 5 Days 5 Hours 5 Min. 5
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Oak Dodson	
14. MOTHER'S MAIDEN NAME Mildred Smith		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Oak Dodson Hurlock, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid haemorrhage 760.5 DUE TO Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 5 days DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 5 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Jan. 23, 1962 to Jan. 28, 1962 , that I last saw the deceased alive on Jan. 28, 1962 , and that death occurred at 9:25 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Jason F. G. Yee, M.D.		ADDRESS (Street, City or town, state) Hurlock, Md.	
PHYSICIAN'S NAME (Type) JASON F. G. YEE, M.D.		DATE SIGNED 1-29-62	
22a. BURIAL, CREMATION, REMOVAL (Specify) Jan 29, 1962		22b. DATE THEREOF Jan 29, 1962	
22c. NAME OF CEMETERY OR CREMATORY Washington Cemetery		22d. LOCATION (City, town, or county) Hurlock, Md. (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE Oak Dodson		ADDRESS Hurlock, Md.	
24a. REC'D BY REGISTRAR 1 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

Mark - Virginia Skinner - Cambridge, Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00581

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>	c. LENGTH OF STAY IN 1b <u>15 hrs 30 min</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Maryland Hospital</u>		d. STREET ADDRESS <u>209 Willis St.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Spicer</u>		4. DATE OF DEATH Month Day Year <u>January 2 19 62</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1 - 2 - 62</u>
9. AGE (In years last birthday) yrs <u>15</u>		IF UNDER 1 YEAR Months Days Hours Min <u>15 30</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George James Spicer</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Ann Long</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mrs. Ruth Spicer - 209 Willis St. Cambridge, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity (wgt-13oz)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>25 hrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1-2</u> 19 <u>62</u> , to <u>1-2</u> 19 <u>62</u> , that I last saw the deceased alive on <u>1-2</u> 19 <u>62</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>1-3-62</u>			
ACTUAL SIGNATURE <u>Eldridge H. Wolff</u> M.D.		DATE SIGNED <u>1-3-62</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Eldridge H. Wolff</u>		<u>15 Locust St. Cambridge, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>	22b. DATE THEREOF <u>1-4-62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cambridge Maryland Hospital</u>	22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dr. Francisweeney-Ry</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>FEB 1 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Haver</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2067315090

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00584

00582

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Crumbridge</u> c. LENGTH OF STAY in lb <u>From 10/10/61</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Eastern Shore State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u> d. STREET ADDRESS <u>MARINERS ROAD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edith Mae Sterling</u> First Middle Last 4. DATE OF DEATH <u>January 21 1962</u> Month Day Year		5. SEX <u>F.</u> 6. COLOR OR RACE <u>W.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Unknown</u> 9. AGE (In years last birthday) <u>86</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Unknown</u> 12. CITIZEN OF WHAT COUNTRY? <u>Somerset</u>		13. FATHER'S NAME <u>Unknown</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> 16. SOCIAL SECURITY NO. <u>220-09-1743</u> 17. INFORMANT <u>Eastern Shore State Hospital</u> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Arteriosclerosis with C.V.D.</u> DUE TO (b) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chr. Brain Synd. Assoc. with Senile Brain Disease with Psych.</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. TIME OF INJURY Hour a.m. p.m. <u>19</u> 20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u> 20e. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>		21. I certify that (I) (this hospital) attended the deceased from <u>10, 10, 1961</u> to <u>1, 21, 1962</u> that (I) (we) last saw the deceased alive on <u>1, 20, 1962</u> and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>Simon Vinkutis</u> 22c. PHYSICIAN'S NAME (Type) <u>Simon Vinkutis</u> 22b. DATE SIGNED <u>January 21, 1962</u>		22d. ADDRESS <u>Eastern Shore St. Hosp. Crisfield</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>JAN. 23, 1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>SUNNYRIDGE CEMETERY</u> 23d. LOCATION (City, town or county) <u>CRISFIELD, MARYLAND</u> (State) <u>—</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>BROADSHAN + SONS</u> ADDRESS <u>CRISFIELD, MD.</u> 25a. REC'D BY REGISTRAR <u>JAN 25 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00583

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 61 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge		d. STREET ADDRESS 306 Maryland Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 306 Maryland Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ida Middle Richardson Last Sullivan		4. DATE OF DEATH Month January Day 24 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 11, 1872
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months 69 Days 13 Hours 11 Min.	11. IF UNDER 24 HRS. Months 69 Days 13 Hours 11 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Green's Island, Dorc.	
11. BIRTHPLACE (State or foreign country) Green's Island, Dorc.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Richardson		14. MOTHER'S MAIDEN NAME Georgeanna	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mrs. Leroy Brown, 306 Maryland Ave., Camb., Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Arteriosclerotic C-V Disease DUE TO (c) 10 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 5 Min.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Month, Day, Year Hour o. n. 19 p. m.	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town) Cambridge, Md.		20f. (County) (State)	
21. I certify that I attended the deceased from January 1962 , to Jan. 24, 1962 , that I last saw the deceased alive on January 23, 1962 , and that death occurred at 11:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1/25/62 DATE SIGNED			
ACTUAL SIGNATURE John Mace Jr. M.D.			
PHYSICIAN'S NAME (Type) John Mace Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 26, 1962	
22c. NAME OF CEMETERY OR CREMATORY Cambridge Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Samuel R. Thomas		ADDRESS Cambridge, Md.	
24a. REC'D BY REGISTRAR JAN 29 1962		24b. REGISTRAR'S SIGNATURE W. L. H. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

00586

00584

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md.</u> c. LENGTH OF STAY IN b. <u>1 Week</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cambridge Md. Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Toddville, Md.</u> d. STREET ADDRESS <u>Toddville, Md.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Melissa</u> Middle <u>Francis</u> Last <u>Todd</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>19</u> Year <u>19 62</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 7, 1896</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Crab Picker</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Dorchester Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Asbury C. Meredith</u>		14. MOTHER'S MAIDEN NAME <u>Dorinda Todd</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-16-7901</u>	
17. INFORMANT <u>Mr. Todd</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mesenteric thrombosis</u> 171X DUE TO <u>Intestinal obstruction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Intestinal obstruction</u> (b) <u>Intestinal obstruction</u> (c) <u>Intestinal obstruction</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Intestinal obstruction</u>	
19. INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>7 days</u> <u>6 mos.</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/11</u> 19<u>62</u> to <u>1/19</u> 19<u>62</u> that (I) (we) last saw the deceased alive on <u>1/19</u> 19<u>62</u>, and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>W. H. Hanks M.D.</u>		22b. DATE SIGNED <u>1/23/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. H. HANKS M.D.</u>		22d. ADDRESS <u>CAMBRIDGE MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Jan. 22, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park</u>	23d. LOCATION (City, town or county) (State) <u>Cambridge, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>		25a. REC'D BY REGISTRAR <u>DATE JAN 29 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>			

3820

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers as 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00587		00585	
1. PLACE OF DEATH a. COUNTY Dorchester Co. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md. c. LENGTH OF STAY IN 1b 1 Day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Md. Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Dorchester Co. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Honga, Md. d. STREET ADDRESS Honga, Md. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thelma Parker Tolley		4. DATE OF DEATH Jan. 13, 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 15, 1906
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crab Picker		10b. KIND OF BUSINESS OR INDUSTRY Seafood	
11. BIRTHPLACE (County & State, or foreign country) Dorchester Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Emory Parker		14. MOTHER'S MAIDEN NAME Eva Flowers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Mr. Vernon Tolley		Address Honga, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X CEREBRAL HEMORRHAGE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) HYPERTENSION, ESSENTIAL (c) PULMONARY DECOMPENSATION		INTERVAL BETWEEN ONSET AND DEATH 2 DAYS UNDET 3 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from 12/18 , 19 61 , to 1/13 , 19 62 , that (I) (we) last saw the deceased alive on 1/13 , 19 62 , and that death occurred at 9:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Alfred R. Maryanov M.D.		22b. DATE SIGNED 1/16/62	
22c. PHYSICIAN'S NAME (Type) ALFRED R. MARYANOV		22d. ADDRESS 136 RACE ST, CAMBRIDGE, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 15, 1962	
23c. NAME OF CEMETERY OR CREMATORY Hoosier Church		23d. LOCATION (City, town or county) (State) Fishing Creek, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		25a. REC'D BY REGISTRAR JAN 18 '62	
ADDRESS Cambridge, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Krause	

